Title 9--DEPARTMENT OF MENTAL HEALTH
Division 45--Division of *[Mental Retardation and]* Developmental Disabilities
[Chapter 3—Care and Habilitation]
Chapter 8 – Targeted Case Management

[9 CSR 45-3.010 Individual Habilitation Plan Procedures]

9 CSR 45-8.030-- Individual Support Plans

Purpose: This amendment changes the name of the division to comply with HB 555 and HB 648 passed by the 95th Missouri General Assembly, which remove the term "mental retardation" from Missouri statutes, updates the rule with more current terminology in the field of developmental disabilities, and modifies the rule to be in compliance with the final federal rule for home and community-based services at 42 CFR Parts 430 and 431. This amendment moves the rule from Chapter 3 to Chapter 8 for the purpose of the organization.

PURPOSE: This rule prescribes procedures for development and implementation of individual[lized habilitation] ***support*** *plans for all individuals receiving services from the Division of [Mental Retardation and] Developmental Disabilities.*

[(1) Terms defined in sections 630.005 and 633.005, RSMo are incorporated by reference for use in this rule. Unless the context clearly indicates otherwise, the following terms mean:
(A) Assessment--the process of gathering information about a client for use by the interdisciplinary team as a basis for the client's individualized habilitation plan (IHP);
(B) IHP amendment--documentation of an interdisciplinary team's change in an IHP at a time other than the time of annual review;
(C) Interdisciplinary team--the client, the client's designated representative(s), the case manager or qualified mental retardation professional, and representatives of services required or desired by the client;
(D) Qualified mental retardation professional (QMRP)--a person with qualifications, training and experience as defined in 42 CFR 483.430; and
(E) Reassessment--data obtained from training programs, results of screenings and formal or informal assessments completed since the previous interdisciplinary team meeting.

(2) Every individual receiving services from the division shall have an IHP.
(A) The interdisciplinary team shall develop an IHP within thirty (30) days after the individual has been found eligible for services.
(B) The IHP shall be based upon a comprehensive, functional evaluation of individual needs. It shall define the individual's current level of independence, identify the projected level of independence that the individual is expected to achieve and describe objectives to reach that level.
(C) The interdisciplinary team shall ensure completion of the following steps to efficiently plan, implement and monitor the IHP: assessment, team synthesis of assessment results, development of

the IHP, development of training programs, implementation of the IHP, reassessments and annual review of the IHP by the entire team.
(D) The IHP shall contain at least the minimum information required to comply with the division's approved IHP format.

(3) The interdisciplinary team shall review every IHP at least annually. IHP reassessments shall be completed within ninety (90) days before annual IHP reviews.

(4) The case manager or QMRP shall regularly monitor implementation of the IHP.
(A) The case manager or QMRP shall periodically observe each individual during implementation of the IHP.
(B) Each month the case manager or QMRP shall monitor every IHP which prescribes residential services or contains habilitative objectives to determine if services are being delivered as planned and, to assure that progress is being made.
(C) At least annually, the case manager or QMRP shall review each IHP which prescribes nonhabilitative services only .

(5) The case manager or QMRP may make changes in IHP objectives only with prior approval of the interdisciplinary team. Addition of training objectives and deletion of training and service objectives also require prior team approval. Addition of service objectives requires notification of the team. The case manager or QMRP may make changes in training plans or methods to insure progress toward achievement of objectives. Any amendment to the IHP shall be documented in the individual's record.

(6) Division facilities shall prescribe services in an eligible individual's IHP or IHP amendment before the services are authorized, delivered or purchased .

(7) The division facility may authorize emergency residential services, respite care or crisis intervention for up to thirty (30) days without prior approval of the interdisciplinary team.

(8) Each division facility shall develop a policy for implementing the IHP process.]

(1) Every individual receiving services from a qualified provider of targeted case management shall have an individual support plan (ISP).

(2) Person-centered planning process. The individual will lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual or guardian, if applicable. All references to individual will include a guardian, or an authorized representative designated by the individual. In addition to being led by the individual receiving services and supports, the person-centered planning process:

(A) Includes people chosen by the individual;

(B) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;

(C) Is scheduled at times and locations of convenience to the individual;
(D) Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient;
(E) Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

(3) The ISP must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual and the scope of services and supports available through the Division, the ISP must:

(A) Reflect the individual's strengths and preferences.
(B) Reflect clinical and support needs as identified through an assessment of functional need.
(C) Include individually identified goals and desired outcomes.
(D) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports.
(E) Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.
(F) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the ISP to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
(G) Identify the individual and/or entity responsible for monitoring the ISP.
(J) Be distributed to the individual and other people involved in the plan.
(K) Include those services, the purpose or control of which the individual elects to self-direct or designate an authorized representative to direct on his or her behalf.
(L) Prevent the provision of unnecessary or inappropriate services and supports.
(M) Document that any restrictions of individual rights must be supported by a specific assessed need and justified in the ISP. The following requirements must be documented in the person-centered service plan:

1. Identify a specific and individualized assessed need;
2. Document the positive interventions and supports used prior to any modifications to the person centered service plan;
3. Document less intrusive methods of meeting the need that have been tried but did not work;
4. Include a clear description of the condition that is directly proportionate to the specific assessed need;
5. Include a regular collection and review of data to measure the ongoing effectiveness of the modification;
6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
7. Include informed consent of the individual, and
8. Include an assurance that interventions and supports will cause no harm to the individual.

(4) The ISP must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation with the exception of providers of assistive technology, dental, durable medical equipment, environmental accessibility adaptations, specialized medical equipment and supplies, and transportation.

(A) Signatures may be added to the plan electronically using a format accepted by MO HealthNet.

(B) When it is not possible to obtain a written signature from the individual or guardian, the Regional Director or designee may approve an exception when the following steps are completed:

1. At least two attempts to obtain the signature are documented.

a. The first attempt must be either by phone or by electronic mail;

b. The second attempt must be documented through certified mail, return receipt for merchandise.

2. A justification must be attached to the ISP describing these and any other efforts made to obtain the signature.

(C) The regional director may require additional efforts by the support coordinator to obtain the signature.

(D) If the exception is approved by the regional director or designee, a copy of the approved exception request shall be sent to all providers of service to the individual.

(4) ISP Review: The ISP must be reviewed, and revised upon reassessment of functional need as required by 9 CSR 45 2.010 at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

(5) ISP amendments require prior written approval from the ISP team and signed in accordance with Section (4), subsections (A) through (D) of this rule. ISP amendments requiring prior written approval shall include:

(A) addition of a new service;
(B) increase or decrease in amount and/or frequency of a service already in place;
(C) termination of a service;
(D) change in guardianship;
(E) limitation of rights;
(F) change in safety or health status; and
(G) change in ISP outcomes.

(6) Changes in legal information, for example arrests, incarceration, court orders, and legal actions other than changes in guardianship shall be documented in the ISP but shall not require prior written approval or signatures if the change does not result in a change in services.

(7) Denial, reduction or termination of a service is subject to appeal as set forth in 9 CSR 45-2.017.

(8) Changes in training plans or methods to ensure progress toward achievement of outcomes already documented in the ISP may be made by the support coordinator as needed without approval of the ISP team.

(9) The division may authorize emergency residential services, respite care or crisis intervention for up to thirty (30) days without prior approval of the ISP team.

(10) If the ISP team has cause to suspect that a designated representative for an adult, or a parent or guardian of a minor child or youth, is acting contrary to the best interest of that individual, discussion and resolution will take place through the person-centered planning process.

(11) Reporting of abuse, neglect or exploitation:

- **(A) If a member of the ISP team has reasonable cause to suspect abuse or neglect of a child or youth, a report shall be made in accordance with section 210.115, RSMo;**
- **(B) Abuse, neglect and misuse of funds or property in an agency that is licensed, certified, accredited, in possession of deemed status, and/or funded by DMH shall be reported and investigated according to 9 CSR 10-5.200; and**
- **(C) If a member of the ISP team has reasonable cause to suspect abuse, neglect or exploitation of an adult in situations other than section (9) of this rule, a report shall be made to the adult abuse and neglect hotline and when applicable in accordance with section 192.2405 RSMo.**

AUTHORITY: section 630.655, RSMo (1994). The rule was previously filed as 9 CSR 10-5.150* ***and 9 CSR 45-3.010****. Original rule filed Nov. 30, 1990, effective April 29, 1991. Amended: Filed May 25, 1995, effective Dec. 30, 1995.*

**Original authority 1980.*